



Scott Walker, Governor
Dave Ross, Secretary

Personal information you provide may be used for secondary purposes [Privacy Law s.15.04 (1)(m)].

ELEVATOR / ESCALATOR ACCIDENT REPORT

Building Name	Owners Name	Registration Tag No.
Street Address	Address	Regulated Object ID.
City, State, Zip	City, State, Zip	Manufacturer

1. **SPS 318.1008(1) (a) Accidents to be reported.** Whenever an elevator or other installation covered by this chapter causes injury to any person, the owner or person in control of the elevator shall notify the department within 48 hours of the accident. The report shall include the date and time of the accident, the location of the elevator or device involved in the accident and description of the accident.

Note: The department may be contacted at phone: (608) 266-7548 during normal business hours. The State Division of Emergency Management can be contacted at (800) 943-0003 during non-business hours.

Name of Injured:	Time of Injury:		
Address:	City:	State:	Telephone:
Nature of Injury:	Did Accident Cause a Fatality: <input type="checkbox"/> Yes <input type="checkbox"/> No		

2. **SPS 318.1008(4) (b) Operation discontinued.** When an accident involves the failure or destruction of an elevator or other installation covered by this chapter and results in injury to a person who requires immediate medical attention, the elevator or device shall be taken out of service and shall not be used again until authorized by the department.
3. **SPS 318.1008(4) (c) Removal of parts restricted.** No part of the damaged installation, construction or operating mechanism shall be removed from the premises until the department grants permission.

Was Elevator Operated after Accident: ☐ Yes ☐ No Was the Elevator Contractor or Inspector Notified: ☐ Yes ☐ No

If Yes, Name(s) and Telephone Number(s):

If Yes, Reason:

Describe fully how accident occurred and state what injured was doing when the accident occurred:

Name(s) and Telephone Number(s) of Witness(es):

Does Elevator have a Permit to Operate: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Last Inspection:
Name of Person Filing Report (Please Print Clearly)	Company or Firm
Signature of Person Filing Report	Date of this Report

Reports Shall Be Filed With the Department of Safety & Professional Services Within 48 Hours of Accident
A Copy of This Report Shall Be Forwarded to the Owner